



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JACK P. MITCHELL, DC

Respondent Name

HARTFORD FIRE INSURANCE CO

MFDR Tracking Number

M4-19-3488-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

MARCH 19, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The DWC-32 form, Box C clearly indicated extent of various diagnoses that was taken into account for the various interpretations reflected by multiple impairments requiring a total of (3) DWC-69 Report of Medical Evaluation being completed."

Amount in Dispute: \$50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford upholds denial of additional reimbursement for CPT 99456-WP MI."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2019	CPT Code 99456-WP-MI Designated Doctor Evaluation	\$50.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
- 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
- 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
- The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 18-Exact duplicate claim/service.
- 247-A payment or denial has already been recommended for this service.
- 1115-We find the original review to be accurate and are unable to recommend any additional allowance.
- 4150-An allowance has been paid for a Designated Doctor examination as outlined in 134.204(J) for attainment of Maximum Medical Improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.

Issues

Is the requestor entitled to additional reimbursement for CPT code 99456-WP-MI (X2)?

Findings

1. On January 28, 2019, the claimant attended a Designated Doctor Examination to determine MMI/IR and extent of injury. The requestor billed the respondent \$1,400.00 for CPT codes 99456-WP-W5, 99456-WP-W6, 99456-WP-MI (X2), 72040-WP, and 73030-WP. The only code in dispute is code 99456-WP-MI (X2).
2. A review of the submitted DWC-69's finds three scenarios with different findings. The Scenario 1 report indicates claimant is at MMI with 8% IR. The Scenario 2 and 3 reports indicate claimant had not reached MMI; therefore, an impairment was not given.
3. To determine the appropriate reimbursement the division refers to the following statutes:
 - 28 Texas Administrative Code §134.210(b)(2) states, "Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill."
 - 28 Texas Administrative Code §134.240(1)(A)(B) states, "Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor."
 - 28 Texas Administrative Code §134.250(4)(C)(iii) states, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR."
 - 28 Texas Administrative Code §134.250(4)(B) states, "When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code."
4. As noted above, the requestor did not provide an impairment rating in the Scenario 2 and 3 reports; therefore, multiple impairments were not performed. The division finds the requestor did not support billing CPT code 99456-WP-MI(X2). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

04/18/2019
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.